Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUSAN VAN DE WATER, MD
3100 TIMMONS LANE STE 250
HOUSTON, TEXAS 77027

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-0031-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER FAILED TO PAY THIS INJURED WORKERS CLAIM AND DID NOT RESPOND TO THE REQUEST FOR RECONSIDERATION EVEN AFTER THE CLAIM WAS SENT BACK AS A REQUEST FOR RECONSIDERATION."

Amount in Dispute: $1,325.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary "The provider originally submitted a bill on or about November 6, 2009 for an amount of $1,212.95. See Attachment. The carrier issued an EOB and reimbursed the provider $1,008.72 for different CPT codes and for different amounts. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive, Ogden, & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 04, 2009	99456-W5-WP, 99456-W8-RE, 99080	$1,325.00	$800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits-NA

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is CPT code 99080 included in the payment for MMI/IR or RTW examinations?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent position refers to a billing for separate NCV/EMG testing done in support of this DD examination. The NVC/EMG services are not in dispute. The services in dispute refer a DD examination. Requestor billed the amount of $800.00 for CPT code 99456-W5-WP for an examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and two body areas were rated per the units in box 24G on CMS-1500. The Diagnoses described in narrative are the cervical spine and left shoulder strain. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the combined MAR for an IR using Diagnosis Related Estimates (DRE) on cervical spine is $150.00. Although ROM measurements were taken on spine, DRE method is the accepted AMA method of determining IR for a spinal region. Per 28 Texas Administrative Code §134.204(j)(C)(ii)(II)(a) the MAR for one musculoskeletal area ROM method on shoulder (upper extremities) is $300.00. The combined MAR for the MMI/IR services rendered is $800.00. The provider also has billed $500.00 for CPT code 99456-RE-W8 for a Return to Work (RTW) examination. However, there is no support in the documentation narrative or reports that any such examination has taken place and is not reimbursable.
2. In regards to CPT code 99080, when billed with RTW exams, 28 Texas Administrative Code §134.204(k) "shall include Division-required reports".

   When billed with MMI/IR, 28 Texas Administrative Code §134.204 states in part (j)(1)(D):

   > Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
   >
   > (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:
   >
   > (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

   Therefore, CPT code 99080 billing for $25.00 is global and not separately payable, and not recommended for payment.
3. The Maximum Allowable Reimbursement (MAR) for the documented services is $800.00 which is the recommended reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 31, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.